STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	06/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/26/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/15/16 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 At this PSR survey, South Shore Health & Rehabilitation was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, areas open to the	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 100 with a census of 70 at the time of the survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage. Quality Review by Lex Brashear, Life Safety Code Specialist on 06/15/16			
K 0064 SS=B Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 Based on observation and interview, the facility failed to ensure 1 of 2, 300 Hall and 1 of 3 Dining Room fire extinguisher pressure gauge readings were in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff and up to 5 residents.	K 0064	ACTION TAKEN: Upon notification of finding, Valley Fire Protections Systems- Jerry Howell was contacted and asked for a consultation and assessment of our current extinguishers from Koorsen. Servicing of the extinguishers has been changed over to Valley Fire Protection Services. On 06/ 23/2016, a service agreement was sign with Valley Fire Protection (service from Koorsen discontinued) to replaced the fire extinguishers with a higher commercial grade extinguisher-Amerex10 pound ABC. IDENTIFICATION OF OTHER RESIDENTS: The	07/15/2016

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	Findings include: Based on observation with the Maintenance Manager on 06/15/16 between 9:35 a.m. and 9:41 a.m., the following fire extinguishers were overcharged: a) Outside resident room 315 b) Outside the Kitchen Based on interview at the time of observation, the Maintenance Manager acknowledged each aforementioned condition. 3.1-19(b) This deficiency was cited on 04/26/16. The facility failed to implement a systemic plan of correction to prevent recurrence.		Maintenance Director did a further audit/ inspection of the other resident's in the facility on 06/15/16 and no other residents were found at risk. MEASURE IN PLACE: 1)Current audit of extinguishers per policy. 2) Inspections per fire Protection company as needed. MONITORING OF CORRECTIVE ACTION: The Maintenance Director and/or Maintenance Assistant, Environmental Supervisor will audit daily x one month with the Fire extinguisher gauge audit form. then weekly ongoing. Valley Fire Protection Services will service as needed. Findings will be reviewed by the QA committee.	